STATEMENT OF

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ON

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Health Insurance Exchanges: Progress Report

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Good morning, Chairman Baucus, Ranking Member Hatch, and members of the Senate Finance Committee. Thank you for the opportunity to speak with you about the implementation of the Affordable Care Act's health insurance Exchanges, now referred to as the Health Insurance Marketplaces. Millions of Americans will purchase affordable health care coverage through the Health Insurance Marketplaces. Since the passage of the Affordable Care Act, the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) have been working with States and other stakeholders to develop and ensure the Marketplaces are ready to provide a consumer-focused experience when open enrollment begins October 1, 2013.

Through the establishment of the Health Insurance Marketplaces, Americans will be able to purchase high quality, affordable private health insurance, regardless of pre-existing conditions, with financial help for those who qualify. The Marketplaces will allow individuals, families, and small businesses to find qualified private health insurance options and apply for financial help using a web site and a streamlined application that can be completed online. At the same time, the Marketplaces will make it easier than ever before to compare available qualified health plans based on price, benefits and services, and quality. The Marketplaces will also help eligible consumers receive premium tax credits or coverage through the Medicaid or the State Children's Health Insurance Program (CHIP).

Additionally, the Small Business Health Options Program (SHOP) will help small businesses who wish to do so provide affordable, quality coverage for their employees. Eligible small businesses will be able to access tax credits through the SHOP and obtain access to information about coverage and options. By pooling people together, reducing transaction costs, and increasing transparency and competition, the Health Insurance Marketplace for individuals and small groups will be more efficient and competitive. Individuals and small businesses can be

confident that the qualified health plan they purchase through the Marketplaces will cover their health care needs.

Since the passage of the Affordable Care Act, CMS has been building the infrastructure that will make the Health Insurance Marketplaces a reality. We have established the framework for the Marketplaces through regulations, guidance, and technical assistance to States.[1] We will continue to provide additional guidance about the Marketplaces as needed, and we will do everything possible to continue to answer specific questions and provide technical assistance to States and stakeholders. With the framework established, we are now focusing on establishing the Federally-facilitated Marketplace for States that do not elect to establish a state-based Marketplace by setting up the process to certify qualified health plans for consumers to choose from, creating and testing the user experience, ensuring the security of the Marketplace portal,[2] and conducting outreach and education so consumers who will buy coverage through the Marketplace know how to access and use it.

We have been hard at work to ensure the Marketplaces will be easy to use, when they become operational beginning October 1, 2013 for the initial open enrollment period. States can elect to run their own Marketplaces,[3] or the Federal Government will operate the Marketplace in States that decide not to operate their own. CMS is structuring the Federally-facilitated Marketplace in a manner that leverages States' knowledge and expertise, as well as existing State programs, laws, and the responsibilities of state insurance departments whenever possible. As of February 1, 2013, nearly half of States have applied to run part or all of their own Marketplaces.

A State may choose to partner with the Federal Government to operate a Marketplace. CMS will supply the infrastructure of the Marketplace when States choose to work with the Federal Government; a State may elect to manage certified qualified health plans, provide consumer assistance and outreach for its eligible residents, or do both This partnership can serve as a path

[1] Every regulation and guidance issued about the Marketplaces is available at http://cciio.cms.gov/resources/regulations/index.html#hie under the heading "Affordable Insurance Exchanges"
[2] Healthcare.gov will be the website for the Federally-facilitated Marketplace. Healthcare.gov will also be able to direct consumers who live in States that are running their own Marketplaces to the appropriate website.
[3] States that are conditionally-approved to run their own Marketplace to date: California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington

for States that are transitioning towards running their own Marketplaces in future years. In each State that has chosen not to partially or fully run its own Marketplace, CMS will leverage States' knowledge and expertise, as well as existing State programs, laws, and the responsibilities of State insurance departments as much as possible.

Regardless of how the Marketplace is managed, consumers will be able to access the Marketplace with ease. All eligible consumers will be able to use a single streamlined application and select from a variety of qualified plans beginning on October 1, 2013.

Improving Coverage for Consumers through Market-wide Reforms

CMS is working to ensure the plans available for people shopping for individual and small group coverage are affordable and offer coverage for essential health benefits. On November 26, 2012, CMS published a proposed regulation in the Federal Register providing updated insurance rules and protections for people enrolled in non-grandfathered individual and small-group health plans.[4] These protections, such as making it illegal for insurance companies to discriminate against people with pre-existing conditions, will apply to all non-grandfathered policies in these markets, whether or not they are part of the new Marketplace.

In addition, on December 7, 2012, CMS published the proposed Notice of Benefit and Payment Parameters for 2014 in the Federal Register.[5] This proposed rule provides detail for issuers on three programs intended to stabilize premiums and the market while encouraging issuers to enroll all eligible Americans. The permanent risk adjustment program transfers funds from issuers with lower-risk enrollees to issuers with high-risk enrollees, enabling issuers to price their premiums for the average enrollee in the individual and small group markets. This is designed to reduce the incentive issuers have to avoid high-cost enrollees. The temporary reinsurance program makes payments to individual market issuers with higher cost enrollees. Finally, the temporary risk corridors program protects against inaccurate rate setting by limiting the extent of issuer losses and gains. In addition to these programs, the proposed rule provided detail to issuers about how the advanced payment of the premium tax credits and the cost sharing

[4] Health Insurance Market Rules: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf
[5] Notice of Benefit and Payment Parameters for 2014: http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf

reduction payments are proposed to be made to issuers. We are working to finalize these proposed rules in the near term.

Beginning January 1, 2014, all non-grandfathered health insurance plans inside and outside the Marketplace must follow certain standards for plan coverage of essential health benefits. All non-grandfathered plans in the individual and small group markets will cover essential health benefits,[6] which include items and services in ten statutory benefit categories, such as hospitalization, prescription drugs, and maternity and newborn care. These benefits will be equal in scope to a typical employer health plan. These proposed rules for defining essential health benefits balance the statutory ten benefit categories and affordability while providing States – the primary regulators of health insurance markets – with flexibility. The benchmark plan approach creates options for each State that reflect the scope of benefits and services typically offered in the employer market in that State.

Non-grandfathered individual and small-group plans will also standardize the percentage of health care costs they will cover. The Affordable Care Act sets standards for the actuarial values, or the percentage of total average costs for covered benefits that a plan is required to cover. In general, actuarial value can be considered a general summary measure of health plan generosity. Each actuarial value corresponds to a "metal," such as silver or bronze, for ease of consumer comparison. The metal levels for plans in these markets are:

- bronze plan with an actuarial value of 60 percent, where on average, a consumer would be responsible for 40 percent of the costs of all covered benefits;
- silver plan, with an actuarial value of 70 percent, where on average, a consumer would be responsible for 30 percent of the costs of all covered benefits;
- gold plan, with an actuarial value of 80 percent, where on average, a consumer would be responsible for 20 percent of the costs of all covered benefits; and
- platinum plan, with an actuarial value of 90 percent, where on average, a consumer would be responsible for 10 percent of the costs of all covered benefits.

[6] Essential Health Benefits: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm

To streamline and standardize the calculation of actuarial values for health insurance issuers, CMS has released a publicly available actuarial value calculator, which issuers can use to determine health plan actuarial values, based on a national, standard population. The proposed rules would also allow States to submit data after January 1, 2015, so that the actuarial value calculator can use a "customized" standard population rather than the national standard population to reflect geographic differences in costs.

Providing Qualified Health Plans in the Marketplace

When consumers visit the new Marketplace on October 1, 2013, they will experience a new way to shop for health insurance plans. In order to build a robust and competitive Health Insurance Marketplace, CMS is working closely with issuers as they prepare qualified health plans that will be available to consumer within the Marketplace. It is important that consumers can select from a variety of high quality, affordable plans. We are also working with health insurance issuers offering coverage outside the Marketplace to ensure that consumers across the board have access to quality coverage.

From the beginning, CMS has been committed to flexibility for States. According to the Final Rule that CMS issued in March 2012,[7] a State that has chosen to run its own Marketplace may establish additional standards for qualified health plans offered in the Marketplace. States establishing their Marketplace are able to work with health insurance issuers to structure qualified health plan choices in the Marketplace that are in the best interest of the State's customers. This could mean that the State establishing its Marketplace allows any health plan meeting the standards to participate in the Marketplace, or it could mean that the State requires health plans to compete to gain access to customers purchasing coverage in the Marketplace. The Final Rule also allows state insurance departments to set specific standards to ensure each qualified health plan gives consumers access to a variety of providers within a reasonable amount of time. Each Marketplace may set the timeframes in which health insurance issuers need to become accredited for their quality performance (if they are not already), allowing

[7] Establishment of Exchanges and Qualified Health Plans Final Rule, http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

consumers in the Marketplace to access new and innovative qualified health plans as they gain accreditation.

States have already had health insurance issuers express interest in operating in a State's Marketplace. States that are running their own Marketplaces are managing plans in different ways. For instance, in Massachusetts, qualified health plans offered in the Marketplace will have very specific features. In Nevada, any insurer offering qualified plans may sell its plans, while in California, there is a statutory requirement for the Marketplace to operate as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with issuers.

CMS has worked with issuers to ensure consumers will have access to many different types of qualified health plans when they come to each Marketplace to shop for health insurance. For example, since May 2012, CMS has consulted with issuers on technical matters related to the eligibility and enrollment process standards for the Marketplaces and has responded to issuer questions and listened to their ideas and feedback. CMS has also provided targeted, comprehensive issuer trainings. CMS has contracts in place to help certify the qualified health plans offered in the Federally-facilitated Marketplace.

Applying for Affordable Health Coverage in the Marketplace

CMS and our State partners have taken a number of steps to ensure that each Marketplace is ready to help consumers find and enroll in private health insurance plans. When consumers visit the website of their Marketplace on October 1, 2013, they will be able to submit an application, find the qualified health plans and financial support available to them; and compare and choose a qualified health plan based on quality, benefits, and cost. This is true regardless of how their Marketplace is run. Consumers can complete a single, web-based, streamlined application[8] to receive an eligibility determination for health benefits coverage and financial help. HealthCare.gov will guide consumers directly to the online application for their State. The

[8] Application Elements: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html

consumer will also be provided clear information about how to complete the application online, apply by phone, or access consumer support.

To develop the applications that individuals and small businesses will use to apply for health benefits coverage in the Marketplaces, CMS consulted with stakeholders, consumer groups, and the National Association of Insurance Commissioners (NAIC) and tested the applications with consumers. CMS released the model applications for public comment on January 28, 2013.[9] The applications will be available for use by States that are running their own Marketplaces, as well as for their Medicaid and CHIP agencies. This means that most individuals can use the same application, and provide information only once, no matter how the individual submits the application and regardless of which program receives the applications. This consumer-focused, unified approach will help millions of Americans enroll in affordable, high quality coverage, while minimizing the administrative burden on States, individuals, and health plans. The applications, along with guidance for States about the applications, will be available in the spring after the current comment period on the model application closes and additional consumer testing is completed.

After a consumer fills out the single, streamlined application, the Marketplace will verify applicant information with existing electronic data sources from Federal and State agencies and commercial entities; this information will be subjected to strong privacy and security protections and its disclosure among the Federal agencies will be subject to compliance with the Privacy Act and all other relevant confidentiality statues and regulations. Consumers will be able to notify their Marketplace of any changes in their status, including marriage, divorce, or a job or income change, that might affect their eligibility easily.

The Marketplace will verify information related to citizenship or immigration status, residency, access to minimum essential coverage, income, and other eligibility factors. Consumers also will be able to keep their coverage from year to year through a simple eligibility redetermination

[9] Video Demonstration of the Application for Comment: http://www.youtube.com/user/CMSHHSgov

process. The Final Rule establishing the standards for the Marketplaces[10] outlined the processes that will guide these eligibility determinations.

Regardless of who operates the Marketplace, CMS is working to ensure streamlined and secure access to a variety of information sources that are essential for operation. CMS is building a single Data Services Hub that all Marketplaces in every State can access. The hub will verify consumer information through one connection to the Social Security Administration, Department of Homeland Security, Internal Revenue Service (IRS), and other sources. The Marketplace will comply with the existing IRS safeguard program to ensure that this tax data is protected. Additionally, the hub will support information exchanges between States, CMS, and IRS to determine available premium tax credits. All verification will be subject to compliance with the Privacy Act and all other relevant confidentiality statutes and regulations.

In the hub, data will be routed, and not stored in the system, ensuring that the data flows where it is needed. The hub will access only the information needed to determine individual eligibility and will not be involved in the selection or certification of health plans.

We have completed the hub's technical design, and have almost completed the services related to Federal and State agency interactions. We have completed a framework for security across agencies and established protocols for connectivity. We have begun to test the hub across agencies and will soon begin to test the hub with States that are the furthest along with implementing their Marketplaces, and will continue testing throughout the year. The hub will begin officially supporting the verification of applicant information on October 1, 2013, when open enrollment begins.

Through these streamlined processes, consumers will be able to fill out an application quickly, receive information about whether they are eligible for premium tax credits or cost-sharing reductions or Medicaid, and begin shopping for qualified health plans, all in one sitting. Consumers can submit an appeal if they disagree with the eligibility determination they receive.

[10] Establishment of Exchanges and Qualified Health Plans Final Rule, http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

As set out in a in recent proposed rule,[11] a State that is running its own Marketplace has an option to establish an eligibility appeals process, in which case, CMS would provide a second-level appeal, if requested by an applicant. If a State chooses not to establish an eligibility appeals process under the proposed rule, then CMS would provide a single level of appeal for the State's Marketplace.

Choosing a Qualified Health Plan through the Marketplace

Eligible consumers will go through a streamlined system, either on the Marketplace website or through a toll-free call center, to choose health coverage that best fits their needs. Consumers will be able to research and compare the available qualified health plan options in the Marketplace so they can make informed choices about their coverage. States are customizing their Marketplace websites in order to best meet the needs of their residents. Similar to the eligibility process, the final Marketplace rule ensures Marketplaces develop and follow high standards regarding the privacy and security of personal information while following Affordable Care Act requirements regarding the use of data.

If a consumer or small business needs help understanding the coverage options offered in the Marketplace, a variety of services will be available to assist them, including online and telephone support. These services will be culturally and linguistically appropriate.

The Navigator program included in the Affordable Care Act will play an important role in educating and helping consumers. For the Federally-facilitated Marketplace, CMS will award the first grants for the Navigator program in June 2013, and training for the Navigator program is under development. Navigators will help consumers by maintaining an expertise about the Marketplace, and by providing information in a fair, accurate, and impartial manner. We will soon be releasing additional guidance on the Navigator program and other assistance programs that consumers will be able to access when shopping for coverage in the new Marketplaces. These programs will also provide help for Medicaid-eligible consumers by walking them through the Medicaid or CHIP enrollment process, or referring them to appropriate resources. Many State Medicaid and CHIP agencies have a long history of enabling providers and other

[11] CMS-2334-P http://www.ofr.gov/OFRUpload/OFRData/2013-00659_PI.pdf

organizations to serve as "application assisters" to provide direct assistance to individuals seeking coverage, and we plan to create similar capabilities for counselors to promote enrollment among individuals in the Marketplace.

Additionally, licensed agents brokers, and online brokers may assist consumers and employers with enrolling in a qualified health plan through the Marketplace. CMS will provide agents and brokers with a portal to the Federal Marketplace website, HealthCare.gov, if the agents and brokers meet the applicable standards required to assist consumers within the Federally-facilitated Marketplace. This Federal web portal will allow agents and brokers to help individuals apply for Federal financial help, and if applicable, select and enroll in a qualified health plan through the Federally-facilitated Marketplace. All agents and brokers who assist individuals and employers in enrolling in qualified health plans through the Marketplace must adhere to applicable State law and regulations.

Educating the Public about the Marketplace

CMS and our State partners are working hard to ensure that people who do not currently have employer-sponsored health insurance are aware of the new tools that will soon be available for them. On HealthCare.gov, people can learn about the Affordable Care Act, review health insurance basics such as understanding what their coverage costs, and interact with a checklist on how to prepare for shopping for coverage on the new Marketplace. On HealthCare.gov[12] and on the HealthCare.gov YouTube channel[13] there are several short videos explaining how shopping for qualified health plans in the Federally-facilitated Marketplace will work.

Our outreach goes beyond the internet. We are using CMS's experience from the implementations of CHIP and Medicare Part D along with input from States and stakeholders to create a consumer outreach and education plan rooted in consumer research, audience segmentation analysis, and State governments' knowledge about the best ways to reach their residents. We are challenging the States that are running their own Marketplaces and those that

[12] http://www.healthcare.gov/marketplace/index.html
[13] http://www.youtube.com/user/HealthCareGov

are working with the Federal Government to reach out to communities and consumers in innovative ways.

CMS is also enlisting allies in Federal agencies and the private sector to reach, engage, and assist potential enrollees. We have an inter-department working group with a wide range of Federal agencies to develop ideas and plans to encourage enrollment and distribute information. Other programs can provide Marketplace referral information in regular notices to clients, post Marketplace information on agency websites, and use local and regional offices to inform and reach out to specific populations. CMS is also working with private partners, including non-profits, provider and trade associations, advocacy groups, corporations and businesses, and faith- and school-based groups to distribute information, encourage enrollment, and support community engagement.

Conclusion

CMS, our State partners, and other stakeholders have been hard at work developing these new Marketplaces since the passage of the Affordable Care Act nearly three years ago. We are developing the architecture that will allow the Marketplace to function, and we are working to develop required systems that will ensure income and eligibility is verified correctly, and all data is secure and that consumers have a seamless experience. Additionally, CMS has been working closely with States that are running their own Marketplaces to provide technical assistance and share information about technology to ensure that every State can smoothly begin open enrollment on October 1, 2013. For example, in 2012 alone, CMS held hundreds of hours of webinars, teleconferences, and meetings, in which thousands of State employees have participated. The progress already made and the foundations we have developed give us confidence that the Marketplace will be ready for consumers on October 1.

As consumers begin to enroll on October 1, their experience will be streamlined, with one application to one Marketplace that provides a variety of high quality, affordable coverage options. Consumers can be sure a qualified health plan purchased on the Marketplace will cover important health care needs that will arise. If a family member has a pre-existing condition,

coverage will be available. Work remains in the coming months, and I look forward to continuing to work with the Committee on implementing this important law.